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ABSTRACT

This document presents a definition and description of anorexia nervosa as a disorder that occurs predominantly in girls and that can affect 1 out of every 250 girls between the ages of 12 and 18 years. The existence of a distorted mental body image among anorexics is discussed and symptoms of the disorder are described, including amenorrhea (absence of menstruation), denial, induction of vomiting, use of laxatives, abdominal pain, discomfort in swallowing, and constipation. Six criteria recommended by the American Psychiatric Association in diagnosing anorexia nervosa are listed. A brief history of anorexia nervosa is presented, beginning with the first documented case of anorexia nervosa in 1689. Several current available treatments are examined and evaluated, including behavior modification, family therapy, psychotherapy, drug therapy, and hypnotherapy. The document concludes by recommending an eclectic approach to the treatment of anorexia nervosa that borrows from the five treatments evaluated in the previous section and individualizes the treatment for each anorexic. (NB)

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ANOREXIA NERVOSA:
ITS SYMPTOMS AND POSSIBLE CURES

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Introduction to Psychological Services

Bucknell University

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OUTLINE

I. A definition and description of anorexia nervosa

II. A brief history of anorexia nervosa

III. An examination and evaluation of current available treatments

   A. Behavior modification
   B. Family therapy
   C. Psychotherapy
   D. Drug therapy
   E. Hypnotherapy

IV. A discussion and explanation of the writer's personally preferred treatment

Anorexia nervosa is a baffling disease, and its cure is very elusive. While cases of anorexia have seemed to increase in the past several years, it is a disease which has been present in human beings since the Middle Ages. In our current society, where dieting is greatly popular, and the lean and thin figure is the norm, anorexia has been viewed by many adolescents as the "in vogue" disease of the late twentieth century. The disorder occurs predominantly in girls, in a ratio of 9:1, and can effect one out of every 250 girls between the ages of twelve and eighteen years (Gross, 1982).

In most cases of anorexia, the individual has a distorted mental body image. He or she will frequently gaze at themself in a mirror and be extremely concerned with his or her appearance. Reduction of food intake, administration of laxatives and diuretics, and excessive exercise are most common ways in which the patient will combat their "fat" body image.

Frequently, the potential anorexic is faced with a stressful situation either at home, at school, or among his or her peers. Many times the individuals who eventually become anorexic are perfectionistic, and are models to their fellow siblings and friends. A weight loss program is begun, and once successful, the fear of weight regain plants the seeds for the disease.

Amenorrhea (absence of menstration) is a common feature of the early stages of anorexia nervosa. In most cases, amenorrhea occurs when 17% of the body weight is lost (Gross, 1982). As body

weight continues to decrease, hypothermia may occur. The patient's pulse rate becomes slower, blood pressure is reduced, edema (water accumulations) may become prominent, and lanugo (fine, soft hair) may appear on the flesh. Occasionally, low blood cell counts, reduced resistence to disease, and hair loss are also prevalent among anorexics. In its worst stages, the disorder may cause cardiac arrest, severe infectious diseases, and ultimately - death.

Research and speculation have contributed a vast array of causes for anorexia nervosa. Many adolescents fear growing up, and use the disease as a way to combat the hormonal changes occurring in their body. The responsibilities of adulthood are feared, and a desire to regress to earlier Freudian stages is evident.

Early symptoms of anorexia nervosa include subtle changes in both behavior and personality. Frequently the defense mechanism of denial is used when the patient is questioned by parents or peers. On occasion, the anorexic may succumb to hunger feelings in which large amounts of carbohydrates are consumed, followed by severe guilt and fear of weight gain. The consequence is the induction of vomitting or laxatives.

Often the patient will complain of abdominal pain, discomfort in swallowing, and constipation (resulting from large doses of laxatives). Cravings for certain delicacies may occur. Sometimes the anorexic will ask a parent to go to a gourmet shop at mid-night. When the requested food is provided, he or she may only nibble at it (Sours, 1980). Many patients take great pleasure in assisting their family members with food preparation, but will rarely eat themselves, or eat very slowly, cutting their food

into many pieces, and never finishing a meal.

The key to diagnosis of anorexia nervosa is early detection. Despite its recent popularity, there are cases that are not being diagnosed in time (Gross, 1982). In 1977, the American Psychiatric Association listed the following six criteria to be used in diagnosing anorexia nervosa:

1. Intense fear of becoming obese, which does not diminish as weight loss progresses.

2. Disturbance of body image, such as claiming to feel fat even when emaciated.

3. Weight loss of at least 25% of original body weight; if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts combine to make the 25%.

4. Refusal to maintain body weight over a minimal normal weight for age and weight.

5. No known physical illness that would account for the weight loss.

6. Amenorrhea
(quoted from Gross, 1982).

However, in evaluating the above characteristics, one must consider other possible diseases rather than only anorexia nervosa. It is possible to have one or some or even all of the above symptoms and not be anorexic. The above items could rather prove to be a gastrointestinal disease, a schizophrenic disorder in which bizarre eating patterns are a part, or the presence of a malignant tumor in the body. However, with early and accurate detection and treatment of anorexia nervosa, the patient's prognosis is most often encouraging.

During the Middle Ages, several cases of anorexia nervosa were recorded, most commonly by priests who were called to offer insight into treating the afflicted individual. Cases were infrequent, and were often blamed on witchcraft and satanic possession.

The first "bona-fide", documented case of anorexia nervosa occurred in 1689 when Richard Morton presented evidence of two anorexics with which he had been affiliated. The first incident concerned an eighteen-year-old English girl whom he had seen starve herself in 1664. He suspected at first that her condition was tuberculosis, until she died during a fainting fit that "preceded from sadness and anorexic cares" (quoted from Sours, 1980). Another instance is described by Morton where the girl's indifference to her starvation amazed him. The third patient he cited in his report was a young boy who starved himself to the point where his body was a mere skeleton.

In 1767, the English physician Naudeau described a case of anorexia which he blamed on the child's demanding mother (Sours, 1980). In 1868, another British doctor, Gull, encountered several occurrences of anorexia nervosa in London. He believed the disease to be caused by problems with the patient's gastric nerves. One of his patients was male, causing Gull to point out that the disease affected both boys and girls.

A French physician, Pierre Janet documented several cases of anorexia nervosa between 1903 and 1909. He attempted to distinguish anorexia into two groups - the first being those that referred to eating, and the second being those who vomitted food after eating.

In 1914, the German pathologist, Morris Simmonds, attributed the cause of anorexia nervosa to hormonal imbalances, and prescribed extracts from the pituitary gland to his patients. During the mid-twentieth century, the use of the psychoanalytic school offered various theories for the causes of anorexia. Suggestions included unconscious pregnancy fantasies, oral-regressed individuals, male identification to the feminine body figure, and mother-child disunity.

Not until the early 1960's was speculation as to the causes of the disease replaced by empirical research. The Gottinger Medical Symposium created the need for a multidisciplinary approach to anorexia nervosa. Through that research, the need for object relations, self-development, gender identity, and drive theory have all been incorporated as causes of anorexia nervosa.

In the early 1970's the American physician Hilde Bruch divided anorexia into two forms - primary or typical, and secondary or atypical. Her assignment to the atypical group was based on the absence of characteristics of the primary syndrome; namely, pursuit of thinness, denial of thinness, preoccupation with food, hyperactivity, and striving for perfection (Macleod, 1982). Thus the classic anorexic is a member of the typical group, whereas the atypical individual might have compounded problems of schizophrenia and anorexia, or the like. In Bruch's book Eating disorders: Obesity, anorexia nervosa, and the person within (1973), she states three current premises of the disease - severe disturbance in the body image, inaccuracy in the way hunger

is experienced, and the conviction of being helpless to change anything about the anorexic's life. It is with this current view of anorexia nervosa that we see in modern terms a disease that has been part of man and womankind for centuries.

When discussing the available treatments of anorexia nervosa, one finds that as many cures are available for the disease, as are causes of the disorder itself. Unfortunately, unlike a patient with a sore throat who is routinely prescribed an antibiotic, extensive research is needed to ascertain the best treatment for each individual case of anorexia nervosa. More complex than just inducing weight gain, the correction of the disease must be part of a complete treatment program. The patient needs to be instructed, and also the family, that in spite of outer appearances, this is not an illness of weight and appetite, but the essential problem relates to inner doubts and lack of self-confidence (Bruch, 1978).

Regardless of the particular treatment or combination of treatments used, several criteria for progress towards a cure must be recognized. The anorexic needs to achieve an accurate body image, restore normal body weight, develop normal eating behaviors, regain a consistent self-identity and self-definition, and re-establish broken intimate relationships with significant others. In the ensuing paragraphs a variety of common techniques

in treating anorexia nervosa will be discussed and explained.

The basic premise of a behavior modification approach in treating anorexia nervosa is founded on the assumption that the eating patterns of the anorexic person have been incorrectly learned. Therefore, current behaviors must be extinguished, and more appropriate ones learned in their place. In order to accomplish this task, operant conditioning is commonly used. When normal eating occurs with regular meal times and appropriate sized meals, the patient is allowed visits from friends, walks outdoors, or other favorite pastimes. In this way the new behavior is positively reinforced. Once reinstatement of eating has successfully occurred, the same principle can be applied to weight gain. One goal of operant conditioning is to reinforce the patient's self-initiated behavior and accurate self-perception, in order for the therapist to be able to foster a sense of positive awareness (Garfinkel & Garner, 1982).

A very favorable advantage of behavior modification is that it can sometimes be administered through an out-patient relationship, rather than requiring hospitalization. Of course, the severity of the case would dictate the style of the program. Some aspects of behavior modification to be considered are - the therapist should refrain from control struggles with the patient, as confrontations over food and eating will only lessen the success of the program, the therapist should direct reinforcement of weight gain more frequently than reinforcement of eating, and the

therapist should allow the patient to choose what or how he or she eats (Garfinkel & Garner, 1982). Empirical research has demonstrated that by following these guidelines, successful use of behavior modification in the treatment of anorexia nervosa has occurred.

Some disadvantages occur when the program is so successful that rapid weight gain causes water and electrolyte imbalances. Because of this, the rate at which weight is gained must be controlled. Another drawback of behavior modification is that in some cases, the only successful implementation of treatment needs to occur in a controlled environment; hence, hospitalization is necessary. In many cases, this is both costly, time-consuming, and degrading to the patient.

The family therapy approach to the treatment of anorexia nervosa is based on the assumption that the origin of the disease is within the interactions of family dynamics. Many times a change in the home environment of the individual will provide the impetus for resolution of the disease.

The basic premise behind family therapy stems from the belief that the origin of the anorexic's quest for perfection stems from behaviors designed by the child to get the approval of his or her parents (Rumney, 1983). Many times the desire by parents to grant continual approval creates an overprotective environment for the child. The child at adolescence attempts to develop peer relationships, and the family responds by increasing their protectiveness.

The task of the family therapist is to join the family system, then to challenge the dynamics of the family while restructuring it. Once the family has become unified to combat the problems of the anorexic, the focus of therapy is placed on the eating disorder. Many times this will occur by the therapist observing the family at a meal. The therapist may concentrate the whole conversation during the meal around food, or may avoid the topic of food completely to get a sense of the family's habits and ritual during meal time. Eventually, the therapist attempts to change the view of the family regarding their relationship to the patient. By insisting that all family members speak for themselves and not be allowed to say how another person thinks or feels, the therapist encourages the right of each person to his or her own psychological space. The therapist also blocks the intrusion by a third person into an interaction between others (Rumnev, 1983).

Family therapy has been respected by many doctors as a very successful treatment for anorexia nervosa. By making the entire family aware of the disease, they can better cope through the treatment and offer a sense of empathy to the patient. Another advantage is that frequently the treatment can occur completely in the home, thereby avoiding the undesirable need for hospitalization. The advocates of family therapy will insist that only through their method can the roots of the disease be corrected.

However, several concerns regarding the use of family

therapy have arisen. By some professionals, the theory is viewed as radical and intrusive into aspects of the family unrelated to the disease. Frequently the rapport between the therapist and the family dictates the results, and if unsuccessful, a new therapist will have to restart treatment with possibly the same prognosis. Likewise, an uncooperative family could make the theory quite ineffective. Concern has also developed regarding whether or not family therapy cures anorexia nervosa or just quells the symptoms. In view of the relatively severe neurotic problems remaining, one can only suspect that such "psychosocial recovery falls short of the resolution of emotional problems resulting from the disease" (quoted from Wilson, 1985).

While behavior modification and family therapy may prove to be effective short term treatments to anorexia nervosa, many doctors agree that psychotherapy and counseling is the cornerstone of long-term management of the disorder. In many cases, the anorexic has regained weight and returned to normal eating habits; however, their self body image and mental attitude of themselves is still impaired.

The therapist using psychoanalysis needs to understand as much as possible about the patient and his or her family, and also must convey an attitude that the patient's beliefs and feelings are genuine to him or her at the present time. The anorexic will not realize they are suffering from the disease, and the therapist will need to work through this obstacle to bring

the disease from the patient's unconscious level to his or her conscious level. Frequently, the defense mechanism of denial is a part of the patient's view of the symptoms. Hence, the anorexic will need to realize that he or she is engaging that defense mechanism. Often times, discussion of other topics besides weight gain provide insight to roots of the problem. Occasionally the anorexic will view the symptoms of their disease as the "price they have to pay" to be thin. If the patient is brought to realize that they are fighting the symptoms and effects of starvation, rather than problems in their school or family life, they may be able to ally with the therapist in attempting to remedy the disease.

In addition to bringing unconscious thoughts to conscious level, another goal of psychotherapy is to assist the patient in correcting their distorted sense of reality. The focal point of reality-orientation is to correct the patient's cognitive distortion. Faulty thinking, erroneous beliefs, and misperceptions about his or her body must be identified and labeled; however, the patient must be encouraged to trust that his or her view and perception are real for the patient at this point in time (Wilson, 1985).

Another area in which psychotherapy is employed is in increasing self-esteem. Psychotherapy helps the patient to recognize the limitations he or she has placed upon him or her self-worth. Therefore, the patient must learn that personal excellence is not required in order to receive self-acceptance.

The therapist must encourage self-acceptance for the anorexic, as he or she must be brought to realize that their helplessness and incompetence can be eliminated by approaching and correcting areas in which he or she has been afraid or reluctant to face.

Often through psychotherapy, the anorexic's incorrect feelings of abandonment and independence can be corrected. The relationship with the therapist can often build on the weaknesses of these areas. Through the patient knowing that he or she will continue to see the therapist despite intervals between appointments and vacations, the anorexic can begin to build on his or her own personal autonomy and independence.

Several problems concerning psychotherapy have been noted. With those severly ill patients, psychotherapy will not effectively solve the problem in an immediate time frame. Frequently, patients will not want to communicate or discuss the disease with the therapist, creating severe resistance towards the counselor. Often times, anorexics with major problems in their home are reluctant to transfer upon the therapist, as they fear the trust of anyone who wants to discuss the disease.

Finally, a concern with psychotherapy is that many times while it reconstructs the thinking of the individual, it does nothing to change the interaction of family members and significant others, which in some instances may also be a serious contribution to the individual's disorder.

A rather controversial method of treating anorexia nervosa

is drug therapy. Used most often in severe cases, several prescribed medications have proven effective in some cases. In instances where depression is a serious facet of the illness, anti-depressants may be used. In severely starved and malnourished anorexics, drugs are generally avoided as they could cause serious cardiac and blood pressure complications. While drugs and medications can prove to be valuable adjuncts in the treatment of anorexia nervosa, it is seldom used as the only form of treatment. Due to the elements of the disease's psychological and environmental causes, it can hardly be used as a treatment in itself.

A small number of physicians and psychiatrists will implement hypnotherapy as a part of their anorexia nervosa treatment. Hypnosis has been used to unblock perceptions of hunger in anorexics, and help the patient to understand the physiological differences between hungry and full. Issues such as self-esteem, body image, and eating habits can sometimes be assessed and corrected during a hypnotic trance. However, since many people perceive hypnosis as relinquishing control - something that most anorexia nervosa patients vehemently resist - it is not a useful therapy for all cases (Baker & Bayer, 1983).

As evident by the previously discussed material, anorexia nervosa is a complicated disease. It is often difficult to

recognize, to assess, and to treat. Rather than mention one specific treatment for such a complex disease, I feel an eclectic approach to the treatment of anorexia nervosa is most effective. Only after the assessment of the patient can one determine the true causes and reasons for the disease in the individual.

If the majority of problems lie within eating habits, then emphasis should be placed on behavior modification. If a powerful mother or demanding significant other(s) prove to be the maximum source of the disorder, the majority of emphasis may need to be placed on family therapy. If self-image, denial of symptoms, and irrational beliefs are creating most of the problems, a psychoanalytic approach to treatment may prove best. While I do not believe that drug therapy and hypnotherapy can be used by themselves to combat anorexia nervosa, I think they can be integrated into the treatment plan, depending upon the needs of the individual. For one anorexic, parts of each of the five treatments discussed may be needed, whereas for another individual, he or she may be best cured with only one treatment system. Other factors such as time-frame and severity of illness once medical help is requested will also determine which approach is more effective. By individualizing the treatment for each anorexic, and providing an eclectic treatment approach, the chances of curing the disorder are much more effective.

BIBLIOGRAPHY

Baker, D. H. & Bayer, A. E. (1983). Adolescent eating disorders: Anorexia and bulimia (Publication 352-004). Blacksburg: Virginia Polytechnic Institute and State University, Virginia Cooperative Extension Service.

Bruch, H. (1973). Eating disorders: Obesity, anorexia nervosa and the person within. New York: Basic Books.

Bruch, H. (1978). The golden cage: The engima of anorexia nervosa. New York: Random House.

Garfinkel, P. E., & Garner, D. M. (1982). Anorexia nervosa: A multidimensional perspective. New York: Brunner/Mazel.

Gross, M. (Ed.). (1982). Anorexia nervosa: A comprehensive approach. Lexington, MA: The Collamore Press.

Macleod, S. (1982). The art of starvation: A story of anorexia and survival. New York: Schocken Books.

Rumney, A. (1983). Dying to please: Anorexia nervosa and its cure. Jefferson, NC: MacFarland.

Sours, J. A. (1980). Starving to death in a sea of objects: The anorexia nervosa syndrome. New York: Jason Aronson.

Wilson, C. P. (Ed.). (1985). Fear of being fat: The treatment of anorexia nervosa and bulimia. New York: Jason Aronson.